Form
6153.1

ADULT LIABILITY AND MEDICAL INFORMATION FORM

NAME OF PARTICIPANT:	PARISH / CLUSTER / SCHOOL GROUP:
HOME PHONE:	WORK PHONE:
CELL PHONE:	EMAIL:

TRIP INFORMATION

ACTIVITY:	DATES OF TRIP:
:Junior Retreat Daylong Arrive: 8:45 AM to 6:00 PM	Jan 31 2026 or Feb 7 2026 Choose one
SUPERVISOR: Maureeen LeGros 262.424.0175	DESTINATION: St. Leonard W173S7743 Westwood Dr Muskego
MODE OF TRANSPORTATION TO AND FROM EVENT: N/A (This retreat is in collaboration with St. Leonard in Muskego & Ben Wagner, singer songwriter)	

Consent to Participate and Indemnity Agreement:

I consent to participate in this activity. I agree to reimburse and indemnify the parish/school (understood to include the Archdiocese of Milwaukee) for all reasonable legal and court fees incurred by parish/school in defending a lawsuit that I may bring against the parish/school which relates to the above named activity if the parish/school is found not legally liable by the courts and prevails in the lawsuit. If the parish/school is found legally liable for injuries sustained by me, this paragraph will not apply.

I understand that the parish/school does not provide any health, accident, or disability insurance for me, and I certify that I have adequate insurance or other monetary means available to me that will respond to any illness or injury that may occur during the activity.

I certify that I have an understanding of this agreement and any risks and hazards associated with the activity described above that I will be participating in. I further understand that I had the opportunity to fully discuss this agreement with a representative of the parish/school to clarify any concerns or questions about the activity or this agreement that I may have had.

PARENT SIGNATURE:	DATE:

Medical Information and Consent

The following information will be used only in the event of an emergency in which you are unable to seek medical attention for yourself.

PHYSICIAN'S NAME:	PHONE:
NAME OF MEDICAL INSURANCE:	POLICY #:
SPECIAL DIETARY NEEDS, ALLERGIES, OR MENTAL/PHYSICAL HEALTH ISSUES WE SHOULD KNOW IN THE EVENT OF AN EMERGENCY:	

Medications: ☐ I am taking medication and will bring all such medications necessary, and medications will be well labeled.

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to be transported to a hospital for emergency medical treatment. I wish to have my spouse/parent advised prior to any further treatment by the hospital or doctor. In the event of emergency, please contact:

SPOUSE / EMERGENCY CONTACT NAME:	DAY PHONE:
EVENING PHONE:	CELL PHONE:

I hereby warrant that to the best of my knowledge, I am in good health and I assume all responsibility for my health.

PARENT SIGNATURE:	DATE:

By entering my full name, I attest that this constitutes my legal electronic signature on this form

OFFICE USE ONLY | DATE RECEIVED